	R MEDICARE & MEDIC				OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
		IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155792	B. WING		10/17/2011	
				ADDRESS, CITY, STATE, ZIP CODE	L	
NAME OF I	PROVIDER OR SUPPLIER	R		DAN JONES RD		
COUNTR	RYSIDE MEADOWS	SLLC		IN46123		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
F0000						
	This visit was fo	or Investigation of	F0000	Preparation and/or executio	n of	
	Complaint IN00	_	10000	this plan of correction ingen-		
	Complaint 11100	09/024.		or this corrective action in		
	Complaint INO	007024 Substantiated		particular, does not constitu	l l	
	_	097024 - Substantiated.		anadmission or agreement I facility of the facts alleged o		
		ficiencies related to the		conclusions setforth in this	1	
	allegations are c	ited at F431 and F9999.		statement of deficiencies. The		
				plan of correction and speci	fic	
	<u> </u>	October 14, 15 and 17,		corrective actions are		
	2011			preparedand/or executed in		
				compliance with state and fe	ederai	
	Facility number:	012534		laws.		
	Provider number	r: 155792				
	AIM number:	pending				
	Survey team:					
	Vanda Phelps, R	?N				
	, undu i noips, i					
	Census bed type					
	SNF 2					
	SNF/NF 4					
	Total 6	01				
	Canqua mayor to	na				
	Census payor ty	•				
	Medicare 25					
	Medicaid 23					
	Other 13					
	Total 61					
	Sample: 7					
	These deficienci	es also reflect state				
	findings cited in	accordance with 410 IAC				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

1WB711

Facility ID:

012534

If continuation sheet

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/17/2011	
		130732	B. WING	DDDEGG CITY CTATE 7ID CODE	10/11/12011
NAME OF I	PROVIDER OR SUPPLIER	R		DDRESS, CITY, STATE, ZIP CODE	
COUNTR	RYSIDE MEADOWS	SLLC		IN46123	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE
1710	16.2.	LEGE IDENTIFICATION ORGANIZATION	1110		BATE
	10.2.				
F0431 SS=E	The facility must e of a licensed phar system of records all controlled drug enable an accurat determines that drugthat an account of	8/11 by Suzanne Williams, RN employ or obtain the services macist who establishes a of receipt and disposition of s in sufficient detail to be reconciliation; and rug records are in order and f all controlled drugs is periodically reconciled.			
	be labeled in accordance accepted profession the appropriate accepted the appropriate accepted in acce	cals used in the facility must ordance with currently onal principles, and include ccessory and cautionary he expiration date when			
	the facility must st in locked compart temperature contr	h State and Federal laws, ore all drugs and biologicals ments under proper ols, and permit only inel to have access to the			
	permanently affixed of controlled drugs. Comprehensive D Control Act of 197 abuse, except who unit package drug which the quantity	provide separately locked, ed compartments for storage is listed in Schedule II of the brug Abuse Prevention and 66 and other drugs subject to en the facility uses single distribution systems in a stored is minimal and a be readily detected.			
	Based on observe interview, the far safe and secure sediscontinued, continued, continued	ation, record review and acility failed to maintain	F0431	F 431 Drug Records, Label/Store Drugs &Biologi It is the intent ofthis facility maintain safe and secure storage of discontinued, controlledClass II – IV	I

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155792 10/17/2011 WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 762 N DAN JONES RD COUNTRYSIDE MEADOWS LLC AVON. IN46123 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5)PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE an unlocked drawer within an unlocked, medications according to the facility policy. (In accordance unattended office which had an open withState and Federal Laws) I. door. This impacted 4 of 4 discharged Actions Taken: Nurses will be residents and 1 of 3 current residents educated by 11/1/11 on the reviewed for drug disposal and involved facility medicationstorage & destruction policy/procedure by twelve discontinued medications. DNS & ADON. Discovered (Residents G, J, K, L, M) Medications were immediately destroyed by ADNS& UM/RN. II. Findings include: Residents Affected: There were no residents affected. Nurses will be educated by 11/1/11 on the During observation on 10/14/11 at 2:15 facilitymedication storage & p.m., with the Administrator and the destruction policy/procedure by Assistant Director of Nursing present, a DNS & ADON. Discovered bag filled with medication cards and Medications were immediately destroyed by ADNS& UM/RN. forms was inside an unlocked drawer in III. Measures Taken: Nurses the office. The door to this office was will be educated/in-serviced by open and the room had been unoccupied. 11/1/11 on thefacility medication storage & destruction policy/procedure by DNS Within the bag, there were twelve cards &ADON. Class II-IV medications of medications as follows: for destruction will be housed in alocked safe in the Medication 1. There were four cards for Resident Room and destroyed per State and FederalRegulations. Said G: room is only accessible by A. 25 tablets of Hydrocodone/APAP, licensed staff, and the safe isonly 5-325 mg. (milligrams), pain accessible by DNS, ADON, and medication, Schedule III controlled UM/RN. All discharged residents will be reviewed in the substance clinicalmeeting (M-F). Weekly B. 58 tablets of Lorazepam 0.5 mg., for med cart auditswill be conducted anxiety, Schedule IV controlled by a licensed substance professional. DNS/designee will verify the proper storage & C. 29.75 cc (cubic centimeters) of destruction ofmedications Lorazepam Intensol 2 mg/ml (milliliter), weekly. IV. Monitoring: All Schedule IV controlled substance discharged residents will be D. 29.5 cc of Roxanol 20 mg/ml, a form reviewed in the clinicalmeeting

Facility ID:

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE COI LDING	NSTRUCTION 00	(X3) DATE COMPI	ETED		
		155792	B. WIN			10/17/2	011	
	NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE MEADOWS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 762 N DAN JONES RD AVON, IN46123				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE	
	of morphinepail II controlled substance of Resider record was compindicated Resider facility on 9/14/12. There was on which contained Hydrocodone/AI pain medication. record was review a.m. It indicates home on 9/16/11. 3. There were the Resident K: A. 16 tablets of insomnia, a Class B. 8 tablets of C seizures and/or a controlled substance. 4 tablets of C an opioid pain in controlled substance of Resident Review of Resider record was compiliated and the recor	ent G's closed clinical leted on 10/17/11. It int G expired in the 1. se card for Resident J 15 tablets of PAP 7.5/325 mg., a Her closed clinical wed on 10/17/11 at 11:07 d she was discharged . To ree medicine cards for a si IV controlled substance clonazepam 0.5 mg. for anxiety, a Class IV nce Dxycodone IR 5 mg., nedication, Schedule II nce ent K's closed clinical leted on 10/17/11 at dicated she had gone			(M-F). Weekly med cart auditswill be conducted by licensed professional. DNS/designed verify the proper storage & destruction ofmedications weekly. DNS and/or design will audit compliance with the facility medicationstorage & destruction policy/procedur weekly for 4 weeks then quarterlyfor 2 quarters. DNS/Designee will completed weekly audit to be presented to the CQI Committee in the CQI Stand Up meeting relamedicationstorage & destruction and the color of compliance with all regular requirements. Our date of compliance is 11/1/11.	e will gnee ne e a dd daily ted to oction. andUp thly cal b% is e f		

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155792		LDING	NSTRUCTION 00	i i	e survey pleted /2011	
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE MEADOWS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 762 N DAN JONES RD AVON, IN46123					
	RYSIDE MEADOWS SUMMARY S' (EACH DEFICIEN REGULATORY OR Resident L. It c Oxycodone/APA 5-325 mg. This controlled substa The resident had 5. There were the Resident M. A. 51 tablets of 5-325 mg. pain III controlled su B. another care Hydrocodone/AI medication, School substance C. 11 tablets of 5-500 mg. pain III controlled substance Unterview with the Nursing on 10/14 indicated she and preferred to do the controlled medications were awaiting destructions.	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) Ontained seven tablets of AP S is a Schedule IV Ince which treats pain. Ingone home on 9/16/11. In the cards for current I Hydrocodone/APAP In medication, Schedule I with 29 tablets of PAP 5-325 mg. pain				SHOULD BE	(X5) COMPLETION DATE	
F9999	3.1-25(n)							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155792		LDING	NSTRUCTION 00	(X3) DATE COMPL 10/17/2	ETED		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE OAN JONES RD				
COUNTRYSIDE MEADOWS LLC				AVON,	IN46123				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PERCEDED BY FULL		(EACH DEFICIENCY MUST BE PERCEDED BY FULL PREF		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
TAG	FINDINGS Unused portions released with the credit shall be do within seven (7) pharmacist or lie witness. This rule was not by: Based on observe interview, the faunused medication resident were domanner. This is residents and 1 controlled reviewed for druttwelve disconting (Residents G, J, Findings included During observate p.m., with the A Assistant Direct bag filled with a forms was inside an office. With twelve cards of the credit shall be desired to the controlled residents of the credit shall be desired to the cre	STATE of medications not e resident or returned for estroyed on the premises days by the consultant censed nurse with a entitle followed as evidenced entitle failed to assure all ons not released to the estroyed in a timely mpacted 4 of 4 discharged of 3 current residents and disposal and involved ued medications. K, L, M)	FS	TAG 0999	F9999 Unused portions of medications not released withthe resident or returne credit shall be destroyed or premises withinseven (7) do by the consultant pharmacor licensed nurse with a witness. It is the intent offthis facility destroyed unused portions medications not released with the timely according to a facility policy. (Andstate Regulations) I. Actions Taken: Nurses will be educated by 11/1/11 on the facilities time medication destruction policy/procedure by the DNS ADON. Discovered Medications were immediately destroyed by the ADON & UM/RN. II. Residents Affected: There were no residents affected: There were no residents affected: Nurses will be educated by 11/1/11 on the facilities timelymedication destruction policy/procedure by the DNS ADON. Discovered Medications were policy/procedure by the DNS ADON.	d for n the days ist	DATE 11/01/2011		
	1. There were	Toda Cardo for Resident				-			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 10/17/2011		
			B. WIN		DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				OAN JONES RD		
COUNTRYSIDE MEADOWS LLC					IN46123		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE
	G:	CII du d /ADAD . 5			immediately destroyed by theADON & UM/RN.		
		Hydrocodone/APAP, 5-					
	325 mg. (millign				III. Measures Taken:		
		itrolled substance			Nurses will be	4 /4 4	
		Lorazepam 0.5 mg., for			educated/in-serviced by 11/ during/followingthe survey o		
	anxiety, Schedu	ie iv controlled			facility timely medication		
	substance				destruction policy/procedure	:	
	C. 29.75 cc (cubic centimeters) of				bythe DNS & ADON.		
	•	sol 2 mg/ml (milliliter),			Class II-IV medications for		
		controlled substance			destruction will be housed in	1	
	D. 29.5 cc of Roxanol 20 mg/ml, a form				alocked safe in the Medicati		
	of morphinepain medication, Schedule				Room and destroyed per Sta		
	II controlled	l substance			and FederalRegulations. Sa	id	
					room is only accessible by licensed staff, and the safe i	sonly	
		ent G's closed clinical					
	_	oleted on 10/17/11. It					
		nt G expired in the			All dischaused residents will	h-a	
	facility on 9/14/1	1.			All discharged residents will reviewed in the clinicalmeeti		
	A 751	10 0 11			(M-F). Weekly med cart	''9	
		ne card for Resident J			auditswill be conducted by a	1	
	which contained				licensed	•••	
	1 -	PAP 7.5/325 mg., a pain			professional. DNS/designee verify the proper storage &	WIII	
		er closed clinical record			destruction ofmedications		
		10/17/11 at 11:07 a.m.			weekly.		
		vas discharged home on			IV. Monitoring:		
	9/16/11.				All discharged residents will		
					reviewed in the clinicalmeeti (M-F). Weekly med cart	iig	
		hree medicine cards for			auditswill be conducted by a	l	
	Resident K:				licensed		
		Zolpidem 10 mg. for			professional. DNS/designee	will	
	-	ss IV controlled substance			verify the proper storage & destruction ofmedications		
		Clonazepam 0.5 mg. for			weekly.		
		anxiety, a Class IV			•		
	controlled su	ıbstance			DNS and/or designee will au	ıdit	

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLETED	
15		155792	B. WING			10/17/2011	
			D. 1111		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹			OAN JONES RD		
COUNTRYSIDE MEADOWS LLC					IN46123		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	C. 4 tablets of 0	Oxycodone IR 5 mg.,			compliance with the		
	an opioid pain r	nedication, Schedule II		facilitiestimely medication			
	controlled substance				destruction policy/procedure weekly for 4 weeks thenquar	torly	
					for 2 quarter.	terry	
	Review of Resid	lent K's closed clinical			10. <u>– qualitori</u>		
		pleted on 10/17/11 at			DNS/Designee will complete	a	
	_	idicated she had gone			weekly audit to be presented		
	home on 9/19/11	•			tothe CQI Committee in the	,	
	Home on 9/19/11				CQI Stand Up meeting relate		
	4 771				timely medicationdestruction	.	
		one medication card for			Administrator/Designee will		
		contained seven tablets of			review all audits in CQI Stan	dUp	
	Oxycodone/APA	AP 5-325 mg. This is a			meeting weekly and in month		
	Schedule IV con	trolled substance which			CQI meeting with the Medica		
	treats pain. The	clinical record of			Director. If threshold of 1009		
	Resident L was	completed on 10/17/11 at dicated the resident had			not met an actionplan will be developed.		
	11:25 a.m. It inc				developed.		
	gone home on 9/				V. This plan of correction		
	gone nome on sy	10,111			constitutes ourcredible		
	5 There were t	hree cards for current			allegation of compliance wi	th	
	Resident M.	mee cards for current			all regulatory requirements		
		CIL 1 1 /ADAD			Our date of compliance is		
		f Hydrocodone/APAP			11/1/11.		
		n medication, Schedule					
	III controlled su						
	B. another card	d with 29 tablets of					
	Hydrocodone/Al	PAP 5-325 mg. pain					
	medication,	Schedule III controlled					
	substance						
	C. 11 tablets of	Hydrocodone/APAP 5-					
	500 mg. pain medication, Schedule						
	III controlle						
		a babbanee					
	Resident M's clir	nical record was reviewed					
		1:35 a.m. It indicated					
	me Hydrocodor	ne/APAP 5-325 mg.					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155792		LDING	NSTRUCTION 00	(X3) DATE COMPI 10/17/2	LETED
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE MEADOWS LLC			<u> </u>	STREET A	DDRESS, CITY, STATE, ZIP CODI AN JONES RD IN46123	3	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE
	discontinue order 5-500 mg. dose very questionable why to be destroyed. this card was 9/1 Interview with the Nursing on 10/14 indicated she and preferred to do the controlled medicing indicated these mediscontinued and	ne Assistant Director of 4/11 at 2:30 p.m. If the Director of Nursing the destruction of ations together. She					